CONFIDENTIAL

Patient Information

Patient Name: _____ Preferred Name _____ Gender:_____ Date: _____
Last, First MI

Birth Date: _____ Family Status: _____ Social Security #: _____ Drivers License #:_____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Number: _____

Address: _____
Street Apt # City State Zip Code

Email Address: _____

Whom may we thank for referring you to our practice?

Health Information

PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING: _____

_____

Previous Dentist: _____ **Date of Last Visit:** _____ **Reason for this visit:** _____

Have you ever had any of the following? Please check YES or NO:

Y/N	Y/N	Y/N	Y/N
☐ ☐ Allergies:_____	☐ ☐ Bruise Easily	☐ ☐ Heart Murmur	☐ ☐ Rheumatic Fever
☐ ☐ Allergy: Aspirin	☐ ☐ Cancer	☐ ☐ Heart Surgery	☐ ☐ Rheumatism
☐ ☐ Allergy: Amoxocillin	☐ ☐ Chemotherapy	☐ ☐ Hemophilia	☐ ☐ Scarlet Fever
☐ ☐ Allergy: Clindamycin	☐ ☐ Chest Pain	☐ ☐ Hepatitis A/B/C	☐ ☐ Shortness of Breath
☐ ☐ Allergy: Codiene	☐ ☐ Cold Sores	☐ ☐ Herpes	☐ ☐ Sickle Cell Anemia
☐ ☐ Allergy: Epinephrine	☐ ☐ Cortisone Medicine	☐ ☐ High Blood Pressure	☐ ☐ Sinus Problems
☐ ☐ Allergy: Flagyl	☐ ☐ Diabetes	☐ ☐ Low Blood Pressure	☐ ☐ Stomach Problems
☐ ☐ Allergy: Ibuprofen	☐ ☐ Dizziness	☐ ☐ Hypoglycemia	☐ ☐ Stroke
☐ ☐ Allergy: Latex	☐ ☐ Drug Addiction	☐ ☐ Jaundice	☐ ☐ Swelling: feet/hands
☐ ☐ Allergy: Penicillin	☐ ☐ Emphysema	☐ ☐ Kidney Disease	☐ ☐ Thyroid Disease
☐ ☐ Allergy: Sulfa Drugs	☐ ☐ Epilepsy or Seizures	☐ ☐ Liver Disease	☐ ☐ Tuberculosis
☐ ☐ Allergy: Tetracycline	☐ ☐ Excessive Bleeding	☐ ☐ Lung Disease	☐ ☐ Tumors
☐ ☐ Allergy: Tylenol	☐ ☐ Excessive Thirst	☐ ☐ Mental Disorders	☐ ☐ Ulcers
☐ ☐ Allergy: Vicodin	☐ ☐ Fainting	☐ ☐ Mitral Valve Prolapse	☐ ☐ Venereal Disease
☐ ☐ AIDS or HIV	☐ ☐ Fever Blisters	☐ ☐ Nervous Disorders	☐ ☐ X-ray or Cobalt Treatment
☐ ☐ Alzheimer's	☐ ☐ Frequent Cough	☐ ☐ Pacemaker	☐ ☐ Actone (Risedronate sodium)
☐ ☐ Anemia	☐ ☐ Glaucoma	☐ ☐ Pain in Jaw Joint	☐ ☐ Aredia (Pamidronte Sodium)
☐ ☐ Arthritis	☐ ☐ Growths	☐ ☐ Pregnancy, Due: _____	☐ ☐ Fosamax (alendronate)
☐ ☐ Artificial Joints	☐ ☐ Hay Fever	☐ ☐ Psychiatric Care	☐ ☐ Phen Phen or Redux
☐ ☐ Artificial Heart Valve	☐ ☐ Head Injuries	☐ ☐ Radiation Therapy	☐ ☐ Zometa (zoledronic acid)
☐ ☐ Asthma	☐ ☐ Heart Disease	☐ ☐ Radiation Treatment	☐ ☐ _____
☐ ☐ Blood Disease	☐ ☐ Heart Lesion	☐ ☐ Recent Weight Loss	☐ ☐ _____
☐ ☐ Blood Transfusion	☐ ☐ Heart Trouble	☐ ☐ Respiratory Problems	☐ ☐ _____

Note to Women: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional or alternative methods of birth control.

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain: _____
- **Name of Physician**: _____ **Phone**: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No If yes, please explain: _____

In case of emergency, whom shall we call: Name _____ **Relationship**_____

Phone Numbers: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctors at the next appointment without fail.

By checking this box I acknowledge I have read and understand this statement and agree to the above mentioned content: ☐

Reviewed by Pt:_____ **Date:**_____ **Reviewed by Dr:**_____ **Date:**_____
Reviewed by Pt:_____ **Date:**_____ **Reviewed by Dr:**_____ **Date:**_____

Responsible Party Information if Not Patient from Page 1

Name: _____ □ Male □ Female □ Married □ Single □ Other _____

Social Security #: _____ Drivers License #:_____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Number: _____

Address: _____
Street Apartment # City State Zip Code

Insurance Information

Primary Insured Persons Information:

Name: _____ Birth Date: _____ ID or SS#: _____
Last First MI

Address: _____
Street City State Zip Code

Employer Name & Address: _____ Group#:_____

Insurance Plan Name and Phone Number:_____

Secondary Insured Persons Information:

Name: _____ Birth Date_____ID#_____
Last First MI

Address: _____
Street City State Zip Code

Employer Name & Address: _____ Group#:_____

Insurance Plan Name & Phone Number:_____

Consent for Services

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

A service charge of 1 ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or her/his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or her/his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

IT IS OUR POLICY TO CHARGE $15.00 PER 15 MINUTES FOR MISSED APPOINTMENTS WITHOUT 24 HOUR NOTICE. THIS FEE MUST BE PAID PRIOR TO SCHEDULING ANY FUTURE APPOINTMENTS

I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content. **By checking the following box I acknowledge that I have read and understand the above mentioned and agree to the content:** □

X_____ **Date:** _____ **Relationship to Patient:** _____

Name of Responsible Party / Parent or Guardian

In order for us to help prepare your insurance forms and assist in making collections from insurance companies to credit to your account, we will need the following authorizations: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims:

X_____

Name of Responsible Party/Parent or Guardian

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to EDENT: **By checking the following box I acknowledge that I have read and understand this statement and agree to the content:** □

Dental History

Patient: _____

So that we may provide you with the best possible care please complete this form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of last Dental visit _____ **Last Dental cleaning** _____ **Last full mouth x-ray** _____
What was done at your last dental visit? _____

_____

Previous Dentist name: _____ Phone _____
Address: _____

How often do you have dental examinations? _____
How often do you brush your teeth? _____
How often do you floss your teeth? _____
Circle the other dental aids you use: Rotadent Perio-Aid(tooth pick) Rubber tip Stimudent
Flosser Waterpick Other: _____

Do you have any dental problems, pain or sensitivity now? □Yes □No
If yes, please describe: _____
Do you feel nervous about having dental treatment? □Yes □No
If yes, please explain: _____

Have you ever had?

Orthodontic Treatment	□Yes	□No
Oral Surgery	□Yes	□No
Periodontal (gum) Treatment	□Yes	□No
Clicking or popping of the jaw?	□Yes	□No
Joint pain?	□Yes	□No
Difficulty in opening or closing your mouth?	□Yes	□No
Mouth odor or bad taste?	□Yes	□No
Dry Mouth?	□Yes	□No
Food getting caught between your teeth?	□Yes	□No
An upsetting dental experience?	□Yes	□No

Do you:

Clench or grind your teeth while awake or asleep?	□Yes	□No
Mouth breathe?	□Yes	□No
Have tired jaw, especially in the morning?	□Yes	□No
Smoke cigarettes or cigars?	□Yes	□No
If yes, how many a day? _____		
Chew tobacco?	□Yes	□No

Are you satisfied with your teeth's appearance?	□Yes	□No
Would you like to have whiter teeth?	□Yes	□No
Would you like to have straighter teeth?	□Yes	□No
Would you like to have straighter teeth if the braces were ***invisible*** ?	□Yes	□No

Is there anything else about dental treatment that you would like us to know? _____

_____

_____

SEE SIDE 2

EDENT

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

Name of Patient: _____ **Date of Birth:** _____
Address: _____ **Telephone:** _____

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose: This form is used to obtain acknowledgement that you have been notified that our *NOTICE OF PRACTICE POLICIES* can be obtained via our office. If you have any further questions regarding the Health Insurance Portability Accountability Act, please refer to the HIPAA web-site: **http://www.hhs.gov/ocr/hipaa/finalreg.html**

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, specialty referrals, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

I, _____, have received acknowledgement of this office's Notice of Privacy Practices and have had full opportunity to read and consider the contents of this Consent form. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, specialty referrals, and health care operations.
I have received the California material fact sheet.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

Acknowledgement of Receipt and Consent: By checking the following box I acknowledge that I have read and understand the above mentioned and agree to the content: □

Print Name X_____ **Date**_____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

Please list any family members or friends that we may discuss your dental needs, treatment and/or financial, and appointments with:

_____

You May Refuse to Sign This Acknowledgement*

REVOCATION OF CONSENT

Right to Revoke: I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, specialty referrals, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Name _____ Date_____

For Office Use:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
_____ Individual refused to sign
_____ Communications barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please Specify)

_____
_____